

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2015
NAME OF PROVIDER OR SUPPLIER ASTER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 741 PARK EAST BLVD LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: October 16 & 19, 2015</p> <p>Facility number: 013045 Provider number: 013045 AIM number: N/A</p> <p>Census bed type: Residential: 12 Total: 12</p> <p>Sample: 5</p> <p>Aster Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE